



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:  DOCTORS HOSPITAL TIDWELL PARKWAY 3701 KIRBY DRIVE SUITE 1288 HOUSTON TX 77098	MFDR Tracking #: M4-03-8878-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:  TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is out contention that reimbursement by the carrier at a rate of approximately **four and one-quarter percent (4.20%)** of Hospital's standard charges does not constitute 'fair and reasonable' reimbursement for the unusually complex and lengthy surgical procedures provided the patient nor is adequate reimbursement considering the anesthesia services and drugs provided the patient during his surgery."

Amount in Dispute: \$37,983.35

### PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this carrier's position that a) the requester failed to produce any credible evidence that its billing for the disputed procedures is fair and reasonable; b) the requester failed to prove its usual and customary fees for the service in dispute is fair and reasonable are consistent with Section 413.011 (b); c) this carrier's payment is consistent with fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code; and d) Medicare fair and reasonable reimbursement for similar or same services is below this carrier's."

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
7/26/2002	T2, JX, YO, YD, 60	Outpatient Surgical Fees	\$37,983.35	\$0.00
			<b>Total Due:</b>	<b>\$0.00</b>

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 24, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 30, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code.
  - T2-Reduction was made on outpatient bill
  - JX-Fair and reasonable reimbursement for the entire bill is made on the 'O/R service' line item
  - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.
  - YD-Duplicate appeal. An appeal of the original audit decision was previously performed for these services. If you disagree with the original appeal decision, you may request medical dispute resolution through the Texas Workers' Compensation Commission.
  - 60-The provider has billed for the exact services on a previous bill
- This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
5. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
- The requestor's position statement states that "It is out contention that reimbursement by the carrier at a rate of approximately **four and one-quarter percent (4.20%)** of Hospital's standard charges does not constitute 'fair and reasonable' reimbursement for the unusually complex and lengthy surgical procedures provided the patient nor is adequate reimbursement considering the anesthesia services and drugs provided the patient during his surgery."
  - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
  - The requestor does not discuss or explain how payment of \$37,983.35 would result in a fair and reasonable reimbursement.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
- The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 TAC §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

#### **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311  
28 Texas Administrative Code §133.307, §134.1  
Texas Government Code, Chapter 2001, Subchapter G

#### **PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

#### **DECISION:**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

10/29/2010

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Health Care Business Management, Director

10/29/2010

\_\_\_\_\_  
Date

## PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**